



**Individual Enrollment Request Form Instructions**

Follow these easy instructions to enroll in The Health Plan Medicare Advantage. If you have any questions please call 1.877.847.7915 (TTY: 711), 8:00 a.m. to 8:00 p.m., seven days a week from October 1 through March 31 and 8:00 a.m. to 8:00 p.m., Monday through Friday from April 1 through September 30.

1. Each applicant must complete a separate form. **DO NOT PHOTOCOPY THIS INDIVIDUAL ENROLLMENT REQUEST FORM FOR REUSE.**
2. Please read carefully, print neatly and **complete the entire Individual Enrollment Form.**
3. **Have the following information:**
  - Your red, white and blue Medicare card -You will need to fill in information exactly as it appears on your Medicare card.
  - Your Medicaid program number, if you receive Medicaid benefits.
  - Your health insurance card(s) for any other insurance you may have besides Medicare and/or Medicaid.
  - Primary care physician’s full name if selecting an HMO plan.
  - Permanent Residence Address - If you use a Post Office box to receive your mail, please add your permanent residential address.
4. **Sign and Date the Individual Enrollment Form.**
  - **Missing signature and/or date will delay your enrollment.**
  - To avoid enrollment delays, please do not submit duplicate Individual Enrollment Forms or apply to the same plan multiple times.
5. **Keep the Member Copy for your records.**
6. **Use the enclosed postage-paid envelope to mail your completed Individual Enrollment Form and other supporting documents.**

<p><b>Enroll Online</b> via our website, <a href="http://www.healthplan.org/medicare">www.healthplan.org/medicare</a> or through the Medicare website, <a href="http://www.Medicare.gov">www.Medicare.gov</a></p>	<p><b>OR, Mail to:</b> 1110 Main St. Wheeling, WV 26003-2704</p>	<p><b>Or, Call:</b> 1.877.847.7915 (TTY: 711) to enroll by phone</p>	<p><b>OR,</b> Give the completed Individual Enrollment Form to your agent for processing</p>
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# THE HEALTH PLAN Individual Enrollment Form

Please contact The Health Plan if you need information in another language or format (Braille).

Print Agent's Name (if applicable): \_\_\_\_\_ AWN: \_\_\_\_\_

<b>Please Provide Your Medicare Insurance Information</b>			
<p>Please take out your red, white, and blue Medicare card to complete this section.</p> <ul style="list-style-type: none"> <li>Fill out this information as it appears on your Medicare card</li> </ul> <p><b>OR</b></p> <ul style="list-style-type: none"> <li>Attach a copy of your Medicare card on your letter from Social Security or the Railroad Retirement Board</li> </ul>	<p>NAME (as it appears on your Medicare card): _____</p> <p>Medicare Number _____</p> <p>Is Entitled To: _____ Effective Date: _____</p> <p><b>HOSPITAL (Part A)</b> _____</p> <p><b>MEDICAL (Part B)</b> _____</p> <p>You must have Medicare Part A and Part B to join a Medicare Advantage plan.</p>		
<p>Please check which plan you want to enroll in:</p> <p><input type="checkbox"/> The Health Plan SecureCare SNP (HMO D-SNP). Plan number H3672-019. \$0-\$35.20 per month.*</p> <p>*Premium depends on your level of Medicaid eligibility. This plan is available to anyone who has both medical assistance from the state and Medicare.</p>			
<p>Birth Date: ____/____/____ MM DD YYYY</p>	<p>Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female</p>	<p>Home Phone Number: (    )</p>	<p>Alternate Phone Number: (    )</p>
<b>Permanent Residence: (P.O. Box is not allowed)</b>			
City:	State:	County:	ZIP Code:
Mailing Address: (only if different from your Permanent Residence Address)			
City:	State:	County:	ZIP Code:
Email Address: (optional) _____			
<input type="checkbox"/> By checking this box, I give The Health Plan permission to contact me electronically regarding member information.			
We request that all medical plan applicants include their primary care physician's name below. If you are applying for an HMO plan or a plan that requires a PCP, then you must provide this information here.			
_____ Physician Last Name	_____ Physician First Name	_____ Physician Practice Name (if applicable)	
Physician Address: _____			
NOTE: You must select a contracted PCP. If you list a PCP that is not contracted or leave this section blank, a PCP will be selected for you. You may change your PCP for any reason, at any time by contacting The Health Plan.			

**Please read and answer these important questions:**

1. Do you or your spouse work?  Yes  No

2. Do you have other health insurance through your or your spouse's employment or retirement plan?

Yes  No If "Yes," please provide insurance company name \_\_\_\_\_

Member ID#: \_\_\_\_\_ Group ID#: \_\_\_\_\_

3. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs. Will you have other prescription drug coverage in addition to The Health Plan SecureCare SNP (HMO D-SNP)?  Yes  No

If "yes," please list your coverage and your identification (ID) number (s) for this coverage:

Name of other coverage: \_\_\_\_\_ ID# for this coverage: \_\_\_\_\_ Group # for this coverage: \_\_\_\_\_

4. Are you a resident in a long-term care facility, such as a nursing home?  Yes  No

If "yes," please provide the following information:

Name of Institution: \_\_\_\_\_

Address & Phone Number of Institution (number and street): \_\_\_\_\_

5. Do you have End Stage Renal Disease (ESRD)?  Yes  No

If you have had a successful kidney transplant and/or you don't need regular dialysis any more, please attach a note or records from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.

6. Are you enrolled in your State Medicaid program?  Yes  No

If "yes," please provide your Medicaid number: \_\_\_\_\_

7. Please check one of the boxes below if you would prefer us to send you information in a language other than English or in an accessible format:  Large Print  Other \_\_\_\_\_

Please contact The Health Plan at 1.877.847.7915 (TTY/TDD: 711) if you need information in an accessible format or language other than what is listed above. Our office hours are 8:00 a.m. to 8:00 p.m., seven days a week from October 1 through March 31 and 8:00 a.m. to 8:00 p.m., Monday through Friday from April 1 through September 30.

**Paying your plan premium**

**You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail or "Electronic Funds Transfer (EFT)" each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month.**

**If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or RRB. DO NOT pay The Health Plan the Part D-IRMAA.**

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this Extra Help, contact your

local Social Security office, or call Social Security at 1.800.772.1213. TTY users should call 1.800.325.0778. You can also apply for Extra Help online at [www.socialsecurity.gov/prescriptionhelp](http://www.socialsecurity.gov/prescriptionhelp).

If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

If you don't select a payment option, you will get payment coupons.

**Please select a premium payment option:**

**Get payment coupons.**

**Electronic Funds Transfer (EFT) from your bank account each month.** \*Please enclose a VOIDED check or provide the following:

Account holder name: \_\_\_\_\_

Bank routing number: \_\_\_\_\_ Bank account number: \_\_\_\_\_

Account type:  Checking  Saving

\* Additional forms may be needed to complete this authorization. Please contact the plan for details.

**Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.**

I get monthly benefits from  **Social Security**  **RRB**

(The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

**Typically, you may enroll in a Medicare Advantage plan only during the Annual Enrollment Period (AEP) from October 15 through December 7 of each year.** There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period. Please read the following statements carefully and check "Yes" if the statement applies to you. By checking "Yes" to any of the following statements, you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled. If none of these statements applies to you or you're not sure, please contact The Health Plan at 1.877.847.7915 (TTY: 711) to see if you are eligible to enroll.

<b>If Special Enrollment Period (SEP), please choose one of the reasons below</b>	<b>YES</b>
I am new to Medicare.	
I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).	
I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date) ____/____/____	

If Special Enrollment Period (SEP), please choose one of the reasons below	YES
I was recently released from incarceration. I was released on (insert date) ____/____/____	
I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) ____/____/____	
I recently obtained lawful presence status in the United States. I got this status on (insert date) ____/____/____	
I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date) ____/____/____.	
I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date) ____/____/____.	
I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.	
I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long-term care facility). I moved/will move into/out of the facility on (insert date) ____/____/____	
I recently left a PACE program on (insert date) ____/____/____	
I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) ____/____/____	
I am leaving or have lost employer or union coverage on (insert date) ____/____/____	
I belong to a pharmacy assistance program provided by my state.	
My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.	
I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date) ____/____/____.	
I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date) ____/____/____	
I was affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA)). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.	
If none of these statements applies to you or you are not sure, please contact The Health Plan at 1.877.847.7915 (TTY users should call 711) to see if you are eligible to enroll. We are open 8:00 a.m. to 8:00 p.m., seven days a week from October 1 through March 31 and 8:00 a.m. to 8:00 p.m., Monday through Friday from April 1 through September 30.	

**PLEASE READ THIS IMPORTANT INFORMATION**

**If you currently have health coverage from an employer or union, joining The Health Plan SecureCare SNP (HMO D-SNP) could affect your employer or union health benefits. You could lose your employer or union health coverage if you join The Health Plan SecureCare SNP (HMO D-SNP).** Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

**Please read and sign below**

**By completing this enrollment application, I agree to the following:**

The Health Plan SecureCare SNP (HMO D-SNP) is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can be in only one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (Example: October 15 - December 7 of every year), or under certain special circumstances.

The Health Plan SecureCare SNP (HMO D-SNP) is available to anyone who has both Medical Assistance from the State and Medicare.

The Health Plan SecureCare SNP (HMO D-SNP) serves a specific service area. If I move out of the area that The Health Plan serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of The Health Plan SecureCare SNP (HMO D-SNP), I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage from The Health Plan when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date The Health Plan SecureCare SNP (HMO D-SNP) coverage begins, I must get all of my health care from The Health Plan SecureCare SNP (HMO D-SNP), except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by The Health Plan SecureCare SNP (HMO D-SNP) and other services contained in The Health Plan Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR THE HEALTH PLAN WILL PAY FOR THE SERVICES.

Out-of-network/non-contracted providers are under no obligation to treat The Health Plan SecureCare SNP (HMO D-SNP) members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

I understand that if I am getting assistance from a sales agent, broker or other individual employed by or contracted with The Health Plan, he/she may be paid based on my enrollment in The Health Plan.

**Release of Information:** By joining this Medicare health plan, I acknowledge that The Health Plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that The Health Plan will release my information including my prescription drug event data to Medicare,

who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the state where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under state law to complete this enrollment and, 2) documentation of this authority is available upon request from Medicare.

**Signature:** \_\_\_\_\_

**Today's Date:** \_\_\_\_\_

**If you are the Authorized Representative and/or Power of Attorney, you must sign above and provide the following information:**  **Authorized Representative**  **Power of Attorney**

Name: \_\_\_\_\_ Phone Number: ( ) \_\_\_\_\_

Street Address/City/State/ZIP: \_\_\_\_\_

Relationship to Enrollee: \_\_\_\_\_

As an authorized representative, please select where all mailings should be sent:

Send to enrollee mailing address

Send to Authorized Representative mailing address

**AGENT USE ONLY**

Appointment Type: \_\_\_\_\_ Scope of Appointment ID Number: \_\_\_\_\_

Print Agent name \_\_\_\_\_

Agent Writing Number (AWN) \_\_\_\_\_ Agent Phone Number \_\_\_\_\_

**NOTE: If Agent takes receipt of this application, signature and date are required below:**

Signature of Agent \_\_\_\_\_

Date Individual Enrollment Request Form received By Agent \_\_\_\_\_

**Agent: Please be sure to copy and maintain this and all pages of the completed application for your records.**

**Office Use Only:**

Name of staff member/agent/broker (if assisted in enrollment): \_\_\_\_\_ Agent ID: \_\_\_\_\_

Plan ID #: \_\_\_\_\_ Group #: \_\_\_\_\_ Mbr/Client ID: \_\_\_\_\_

Effective Date of Coverage: \_\_\_\_\_

Date Received: \_\_\_\_\_ Check Number: \_\_\_\_\_ Check Amount: \_\_\_\_\_

ICEP/IEP: \_\_\_\_\_ AEP: \_\_\_\_\_ OEP: \_\_\_\_\_ SEP (type): \_\_\_\_\_ Not Eligible: \_\_\_\_\_



### Discrimination is Against the Law

The Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. The Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact The Health Plan Customer Service Department.

If you believe that The Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: The Health Plan Appeals Coordinator, 1110 Main Street, Wheeling, WV 26003, Phone: 1.877.847.7907, TTY: 711, Fax 740.699.6163, Email: [info@healthplan.org](mailto:info@healthplan.org). You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance The Health Plan Customer Service Department is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201  
1.800.368.1019, 1.800.537.7697 (TDD).

Complaint forms are available at  
<http://www.hhs.gov/ocr/office/file/index.html>.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-877-847-7907 (TTY: 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-847-7907 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-847-7907 (TTY: 711)

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-847-7907 (ATS: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-847-7907 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-847-7907 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-847-7907 (TTY: 711).번으로 전화해 주십시오.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-847-7907 (телетайп: 711).

ملحوظة: إذا كنت تتحدثت اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-847-7907 (رقم هاتف الصم والبكم: 711).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-877-847-7907 (TTY: 711) पर कॉल करें।

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-877-847-7907 (TTY: 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-877-847-7907 (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-877-847-7907 (TTY: 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-847-7907 (TTY: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-877-847-7907 (TTY: 711)まで、お電話にてご連絡ください。

Wann du Deitsch (Pennsylvania German / Dutch) schwetzsch, kantscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-877-847-7907 (TTY: 711).

AANDACHT: Als u nederlands spreek, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 1-877-847-7907 (TTY: 711).

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-877-847-7907 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-877-847-7907 (телетайп: 711).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-877-847-7907 (TTY: 711).